STRATEGY RESEARCH PROJECT

JOINTNESS AND PUTTING PREVENTION INTO PRACTICE: THE ROLE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

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USAWC CLASS OF 1997

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ABSTRACT

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TITLE: Jointness and Putting Prevention Into Practice: The Role of the Assistant Secretary of Defense for Health Affairs

FORMAT: Strategy Research Project

DATE: 1 April 1997 PAGES: 38 CLASSIFICATION: Unclassified

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) and the three Uniform Service Surgeons General (Army, Navy, Air Force) endorsed the U. S. Public Health Service Put Prevention Into Practice (PPIP) Campaign in 1994. Working from different templates, each service is implementing various efforts to promote the PPIP initiative. This paper examines how the ASD(HA) has facilitated the implementation of PPIP, and has articulated the goal and process of using PPIP in the Military Health Service System (MHSS). The paper will demonstrate that to improve the delivery of preventive health care services through the PPIP initiative, the ASD(HA) should provide prescriptive direction and oversight to the uniform services. This type of management will reduce duplication of effort, enhance standardization of practices, and encourage service interaction. Examples are offered to demonstrate the value of collaboration and continued emphasis on disease prevention and health promotion activities; all working toward a healthier and more productive MHSS. The ASD(HA) has a unique opportunity to not only improve the delivery of clinical preventive services with implementation of the PPIP initiative, but also serve as a role model of health-promoting behaviors for other health care systems around the country.

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Preventive health care has never been more important than today. It has become the mantra of the 1990s[1] and an important component in proposals for health care reform.[2] Increasingly, disease prevention and improved health status are becoming the desired product sought by purchasers of health care.[3] The inherent logic to health promotion and disease prevention is that it is more sensible to prevent the occurrence of diseases, or diagnose and intervene early, than to delay treatment with resultant irreversible health damage.[4]

Inaugurated in 1994, the Put Prevention Into Practice (PPIP) initiative is a national campaign to improve the delivery of preventive health care services by various providers (physicians, nurses, nurse practitioners, physician assistants, other allied health professionals) to improve the health of all Americans. The Office of Disease Prevention and Health Promotion, U. S. Department of Health and Human Services, designed the campaign to achieve health promotion and disease prevention objectives for the nation. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) and the three Uniform Service Surgeons General (Army, Navy, Air Force) have endorsed this initiative and implemented various efforts to promote its use. Unfortunately, limited collaborative effort between the ASD(HA) and the three services has resulted in each working from different templates. The idea of thinking globally but acting locally to expedite the process has merit, but it can not be at the expense of continuity and uniformity.

The intent of this project is to determine if PPIP is a part of a clearly focused Department of Defense (DOD) wide effort to emphasize prevention-oriented versus an illness-oriented Military Health Service System (MHSS). The focus has been on how well ASD(HA) has facilitated the implementation of PPIP, to include articulating the goal and process of using PPIP in the MHSS. To improve the delivery of preventive health care services through the PPIP initiative, the ASD(HA) should provide prescriptive direction and oversight to the uniform services. This type of management will reduce duplication of effort,

enhance standardization of practices, and encourage service interaction. PPIP represents a paradigm shift within the MHSS. Clinicians must prepare and change their behavioral patterns from individual and curative to community and preventive. Additionally, there must be a locus of control to the patient. To achieve this, some clinicians may need to develop skills in helping to empower patients and in counseling them to change certain health-related behaviors.[5]

Prevention is not new and should not be thought of as an additional program. It is a standard of medical care. Promoting a culture of prevention first, integrated into the delivery of all medical care within the Military Health Service System, represents a major DOD effort that requires leadership and direction.[6] This leadership emanates from the senior medical leadership at DOD, through the Service Surgeons General, TRICARE Lead Agents, Regional Medical Commanders, to the local Medical Treatment Facility Commanders. The Office of the Assistant Secretary of Defense (Health Affairs) has a tremendous opportunity to not only improve the delivery of clinical preventive services through implementation of the PPIP initiative, but also serve as a model of health-promoting behaviors for other health care systems around the country.

HISTORICAL PERSPECTIVE

The very popular buzzwords, prevention and wellness, are often used interchangeably. While they are related, they are very different. Wellness encompasses the whole person. It is the healthy balance in a person's physical, mental, emotional, social, and spiritual life.[7] However, defining prevention can be elusive. It refers to the tools or methods used to achieve wellness. Traditionally, prevention is subdivided into primary, secondary, and tertiary prevention. Primary prevention is defined as those activities undertaken to prevent the occurrence of disease or illness, whereas secondary prevention is those activities undertaken to intervene after disease can be detected but before it is symptomatic (screening and treatment). Those activities undertaken to prevent the progression of symptomatic disease or illness is defined as tertiary prevention.[8]

Health care expenditures have more than tripled in the United States over the past thirty years.[9] The national investment in prevention is only three percent of the total annual health care costs[10], despite the fact that nearly a million deaths annually and approximately seventy percent of the health care expenditures can be attributed to preventable diseases.[11] The primary cause of death for most Americans has shifted from diseases that required medical intervention to control to diseases over which considerable control can be exerted by simply changing behavior.[12] McGinnis concludes that half of all deaths in this country are lifestyle related.[13] The incorporation of preventive services into the routine of clinical medicine became an important topic on the national agenda of Canada and the United States.

Canadian Task Force

It was not until the 1970s that the role of health promotion and disease prevention became recognized as a priority area of national health policy. The Canadian government launched one of the first comprehensive efforts to examine the promotion of public health. In 1976, it convened the Canadian Task Force on the Periodic Health Examination (CTFPHE). Examining preventive services for 78 target conditions, the CTFPHE provided recommendations based on the strongest evidence of effectiveness. It published its first monograph in 1979 with periodic revisions as new evidence became available. In 1994, a

compilation of the CTFPHE's works was published in *The Canadian Guide to Clinical Preventive Health Care*.[14]

U. S. Task Force

The U. S. Preventive Services Task Force (USPSTF), a body of preventive care experts, was established by the U. S. Public Health Service in 1984. Like the Canadian Task Force, it developed a system for rating the quality of scientific evidence in determining the appropriate use of preventive interventions. The methodology used by the USPSTF was similar to that of the CTFPHE.[15] Preventive services recommended by the task force demonstrate compelling evidence of effectiveness and that the benefits outweigh the risks. The task force works in close collaboration with primary care medical specialty societies (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, etc.) and federal government health agencies. The USPSTF also collaborates with the Canadian Task Force, promoting a binational effort to review evidence and develop recommendations on preventive services.[16] In 1989 and 1996, the USPSTF published the first and second editions of the *Guide to Clinical Preventive Services*. This *Guide* is a summary of the evidence for nearly 200 screening tests, counseling interventions, immunizations, and chemoprophylactic regimens.[17]

Healthy People 2000

Healthy People 2000, National Disease Prevention and Health Promotion Objectives, was released in 1990. Growing out of a health strategy initiated in 1979 with publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and expanded in 1980 with publication of *Promoting Health/Preventing Disease: Objectives for the Nation*, *Healthy People 2000* offers a vision for the new century.[18] It is a product of an unprecedented national consensus effort led by the U. S. Public Health Service. *Healthy People 2000* has three goals for Americans: to increase their span of healthy life, to reduce health disparities among population groups, and to achieve access to preventive services for all.[19] *Healthy People 2000* clarifies the what and why of those activities that promise the greatest results in improving health status.[20]

Put Prevention Into Practice

The USPSTF *Guide* recommends what clinical preventive services should be delivered, and *Healthy People 2000* gives measurable objectives that the delivery of clinical preventive services should achieve. Still missing, however, was a program for delivering the necessary clinical preventive services. Finally, in collaboration with numerous national health organizations, the "Put Prevention Into Practice" (PPIP) campaign was launched by the federal government in 1994.[21] Designed by the U. S. Public Health Service, the campaign's goal is to overcome barriers to the delivery of clinical preventive services by providing a systematic method for the delivery of such care. Earlier prevention campaigns focused on specific services or diseases or emphasized a particular age group or gender. PPIP is a multifaceted educational initiative consisting of a flexible set of reference materials and practical tools, all research based, that cover the whole range of disease prevention and health promotion activities that can be done in a primary care office or clinic. It requires a team approach involving all participants in the delivery of clinical preventive services. Additionally, as documentation and performance measurement become increasingly important, the PPIP materials serve as quality improvement tools for enhancing clinical preventive service performance.[22]

VALUE OF PREVENTION

Many of the major chronic diseases in America are preventable through individual and community efforts. Many of these efforts are information based; helping people acquire the facts, understanding, and skills that enable them to reduce their health risks or participate responsibly in managing their health.[23] The USPSTF *Guide* establishes the effectiveness of a number of screening, counseling, and immunization procedures to reduce the risk of morbidity and mortality from cancer, heart disease, and other chronic conditions.[24] Some results are immediate, such as reduced measles incidence following a national immunization effort; others become evident over time, as in reduced cancer incidence from smoking cessation. More than ever before, patients, providers, payers, and policymakers have widened coverage of clinical preventive services as part of their efforts to improve health and control health care costs. Achievement of preventive health goals is often used as a measure of quality by insurers and other monitoring groups.[25]

A core component of primary care practice is the delivery of clinical preventive services.[26] Woolf notes that the patient's preventive care is a seamless integration of all aspects of health care into a comprehensive health maintenance plan under the management of the primary care provider.[27] Furthermore, he encourages the decision-making as a collaborative effort between the clinician and the patient where the patient makes informed decisions about their life style and health care.[28] Although the USPSTF *Guide* has established the efficacy of many clinical preventive activities, rates of performance remain surprisingly low throughout the health care system. Providing preventive service is realistic and practical, as well as good medicine, but several barriers have deterred optimal delivery.[29]

Barriers To Preventive Services

Anything that interferes with the provision of preventive services can be defined as a barrier.[30] They can occur at any level and can affect both patient and physician.[31] Parallels to the barriers found in civilian health care can be found in the MHSS. Woolf describes a lack of motivation on the part of the clinician as a very basic barrier. Health promotion and disease prevention are less intellectually stimulating and challenging than providing curative medicine and treating diseases.[32] The majority of physician training

is in disease intervention, not prevention, therefore their practice systems are more often oriented toward acute care than prevention.[33] Additionally, the delay or absence of immediate feedback on delivery of preventive services contributes as a clinician attitudinal factor.

Another combination of barriers is the uncertainty about which preventive services to provide, physician skepticism of the effectiveness of such services, and little to no reimbursement for clinical preventive services.[34] It was this skepticism that prompted the U. S. Public Health Service to establish the U. S. Preventive Services Task Force (USPSTF) in 1984.[35] The uncertainty about which services to provide is addressed through guidelines set forth by the USPSTF and others using evidence-based approaches to specify the proper indications for a variety of clinical preventive services. The details of how to perform the recommended clinical preventive services are the principle focus of the PPIP *Clinician's Handbook of Preventive Services*[36] and Woolf's book, *Health Promotion and Disease Prevention in Clinical Practice*.[37] Inadequate reimbursement for clinical preventive services and a patient's lack of health insurance are health care systems factors. This is less of an issue for active duty military personnel, but certainly affects family members and retirees who use the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under TRICARE or Medicare.

A lack of office or clinic systems to promote preventive care is one of the most prevalent disincentives. Leininger et al., notes that a system is a series of routines, tools, and specific roles for office staff and physicians that consistently address each step in efficiently performing preventive care in an office or clinic.[38] These systems are tailored to specific practice needs. Preventive care is most likely to occur when office staff have carefully considered the barriers to and opportunities for preventive care in their setting, understand the importance of prevention, have implemented systems and procedures for incorporating preventive services into the practice, and have a mechanism in place to provide feedback. An organized, systematic plan encourages a team approach, with several members of the office staff sharing responsibility. The Put Prevention Into Practice (PPIP) initiative provides practitioners with implementation tools (e.g., *Clinician's Handbook of Clinical Preventive Services*, patient health guides, flow sheets, chart stickers, patient reminder post cards, etc.) for providing preventive services in the primary care setting.[39]

The competing demands on physician's time, another barrier, can be at least partially compensated by an increase in overall office efficiency.[40]

Patient factors, e.g., patient education, lack of commitment and motivation for behavioral changes, fear, or lack of access to health care, also serve as barriers to the delivery of preventive services. Preventive care cannot be delivered effectively without active patient involvement. At the very least, they must consent to receive preventive care. Studies indicate that there is a high level of patient interest in preventive services, usually higher than clinicians expect.[41] Patients are exposed to a myriad of literature that directly influence their expectations and demands for preventive services. Clinicians occasionally underestimate the valuable role that patients can play in tracking and prompting their own preventive care.

Finally, lack of access to care is another barrier to clinical prevention. This is a common barrier in the Military Health Service System due to organizational resource and administrative constraints. Maximizing the efficient use of medical resources and making every patient encounter (acute and chronic) a teachable moment and an opportunity to practice prevention are beneficial.

THE MILITARY HEALTH SERVICE SYSTEM

As one of the nation's largest health care systems, the Military Health Service System's (MHSS) primary military medical mission is to maintain the health of 1.7 million active duty service personnel and to be prepared to deliver health care during times of war. Additionally, it offers health care services to 6.6 million non-active duty beneficiaries such as family members of active duty personnel and military retirees. This health care is provided by the Army, Navy, and Air Force from more than 600 military hospitals and clinics worldwide at an annual cost exceeding $15 billion. [42]

DOD's direct health care system is supplemented by a DOD-administered insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS accounts for approximately 25 percent of the MHSS budget.[43] Post-cold war contingency planning scenarios, efforts to reduce the overall size of the military forces, federal budget reduction initiatives, and base closures and realignments have all heightened scrutiny of the size and make-up of the MHSS. TRICARE, DOD's new nationwide managed health care program, is to provide the reform and be the overarching umbrella under which all health care services will be provided. TRICARE is intended to improve access to care for the military community while maintaining quality and controlling costs. It involves a partnership between the military and civilian health care communities.[44]

The provision of effective, efficient, systematic clinical preventive services is a cornerstone of national health care reform and health care within DOD. Having endorsed the goals of the Healthy People 2000 initiative, ASD(HA) established its own Promoting Health 2000 objectives. PPIP greatly enhances and compliments these ongoing efforts. The ASD(HA) embraced the PPIP initiative to help the busy clinician focus on doing essential preventive care and to provide the clinician the tools to enhance his or her effectiveness and efficiency. Each service has developed and implemented several preventive innovations throughout their respective organization. Some efforts have been collaborative, but the majority have been service-specific.

Put Prevention Into Army Practice

On 1 October 1995, the U. S. Army Environmental Hygiene Agency was officially redesignated the U. S. Army Center for Health Promotion and Disease Prevention (USACHPPM).[45] Health Promotion and Wellness is a Directorate and one of several missions of the USACHPPM. The USACHPPM's vision is "to be a world-class center of excellence for enhancing military readiness by integrating health promotion and preventive medicine into America's Army."[46] As a proponent of the U. S. Army Medical Command (USAMEDCOM), the USACHPPM developed the Army's strategy for implementation of PPIP.

Setting the tone for each Service PPIP kick-off campaign, the U. S. Air Force sponsored the first Put Prevention Into Practice Implementation Conference in October 1994. From this conference, three Army demonstration sites were selected. The U. S. Public Health Service PPIP Education and Action Kits were procured and distributed throughout the Army Medical Department by March 1995. In September 1995, the USAMEDCOM sponsored an Army specific PPIP Implementation Conference. The USACHPPM developed and distributed an Army PPIP Implementation Manual. The contents of this manual include an implementation guide, PPIP articles and references, PPIP conference proceedings, and best practice initiatives from various Medical Treatment Facilities (MTF) throughout the Army Medical Department. The Army PPIP Implementation Manual provides the general, centralized guidance for each Army MTF or Army Regional Medical Command to decentrally tailor and develop their own PPIP strategies. A health promotion process action team to identify the needs and develop the processes is the commonly used practice among MTFs. The resounding theme is that there must be a preventive medicine-primary care partnership and that primary care, prevention and health promotion sustain and enhance readiness.

Put Prevention Into Air Force Practice

In the fall of 1994, the Air Force established the Office for Prevention and Health Services Assessment (OPHSA). With its primary focus on prevention programs, health status assessment and managed care, this interdisciplinary team was organized to advance prevention and provide data for policy decisions.[47] The OPHSA, in collaboration with the Office of the Air Force Surgeon General, developed the strategy for implementation of put prevention into Air Force practice.

Undertaking several ambitious goals, the Air Force sponsored Triservice Put Prevention Into Practice Conference, succeeded in demonstrating the need for PPIP in the MHSS and a commitment at the highest levels of DOD. The results of the October conference were presented at the January 1995 Triservice TRICARE Conference. The Air Force has briefed PPIP to its senior leadership and conducted several other PPIP training and implementation symposiums and meetings.[48] The OPHSA developed and distributed an implementation manual containing PPIP materials similar to that used in the Army's manual. The PPIP *Clinician's Handbook* was centrally procured and issued to every Air Force primary care provider. Additionally, PPIP Education and Action Kits were distributed to each Air Force MTF.

To demonstrate the Air Force Medical Service's (AFMS) commitment to medical readiness, managed care, and prevention, the Air Force Surgeon General specified that $25 million in FY 96 medical operations funds be dedicated to health promotion and disease prevention initiatives. Initially experiencing a wide variability among MTFs as to the level of PPIP implementation and training, the Air Force Surgeon General directed throughout the AFMS that MTFs appoint a PPIP coordinator and assemble a multidisciplinary prevention team to develop the infrastructure necessary to successfully implement PPIP. The AFMS espouses that everyone know what PPIP is and understand that they have a role to play in it.

Put Prevention Into Navy Practice

Preventive medicine and health promotion is a proponent and mission of the Navy Environmental Health Center (NEHC) under the auspices of the Chief, U. S. Navy Bureau of Medicine and Surgery. After attending the Triservice Put Prevention Into Practice Conference in October 1994, NEHC was designated the program manager for all health promotion activities. This included PPIP development, implementation and ongoing review.[49]

Like the USACHPPM and OPHSA, the NEHC procured and distributed U. S. Public Health Service PPIP materials (e.g., *Clinician's Handbook* and Education and Action Kits) throughout the Naval Medical Department. Additionally, a Navy PPIP implementation manual, tailored from the Army and Air Force versions, was developed and issued at the NEHC sponsored Health Promotion Course in March 1996.[50] Similar to the USACHPPM, the NEHC provides centralized PPIP guidance, allowing for decentralized execution.

UNITY OF EFFORT

The Department of Defense, with an emphasis on readiness and prevention, maintains a commitment to performing high-quality clinical preventive services. It is moving increasingly toward an emphasis on ambulatory care for cost reduction, quality improvement and the prevention of premature injury, illness, and death. It has provided important leadership in partnering with the U. S. Public Health Service in the development, dissemination, and evaluation of the PPIP materials. The presence of the ASD(HA) and the Surgeons General carried a strong message at the Secretary, Department of Health and Human Service's press conference that officially launched the PPIP campaign. J. Michael McGinnis, Assistant Surgeon General, U. S. Public Health Service, notes that the DOD involvement with the PPIP campaign continues to be an influential factor for the promotion of PPIP within civilian health care organizations.[51] DOD medical facilities are competing with these civilian organizations for patients. Without prevention, DOD will lose patients to competitors that offer better preventive programs.

The mandate to improve the delivery of preventive services and to integrate prevention into the MHSS is very clear from the senior medical leadership. A unity of effort is crucial for the promotion of clinical preventive services because of the vastness of the task to provide clinicians and patients with clear information and consistent messages about preventive care.[52] If preventive programs are standardized, service members can go from assignment to assignment and expect to see and hear the same types of information, without conflicting messages.

Preventive health care and health promotion are central to the ASD(HA) philosophy, but currently no overall policy or structure exists to operationalize this philosophy. A DOD Health Promotion Coordinating Committee, with triservice representation, was initially used to perform PPIP health promotion coordinating and information dissemination functions. The value of this forum was never realized, and it soon dissolved. The ASD(HA) has taken a performance based management approach to providing oversight of the PPIP campaign throughout the MHSS.[53] In this approach, each of the three services may utilize different processes to reach a common goal. Their efforts must all pull in the same direction, and their contributions, which can be best practices, must fit together toward the success of the MHSS--without gaps,

without friction, without unnecessary duplication of efforts. It places the burden of PPIP collaboration for innovative initiatives on the three services.

Given the existing diversity of practices in the MHSS, there is no single set of preventive services that is appropriate for all patients in all settings. PPIP is not designed to be a cookie cutter approach to clinical prevention. Several different interventions targeting different aspects of preventive service delivery, different provider styles, and different types of health care organizations are needed.[54] However, with the challenge of working with three services, a collaborative system, coming from the ASD(HA), is necessary to help implement preventive clinical services effectively and efficiently.

A COLLABORATIVE SYSTEM

In a health care delivery system that is rapidly becoming managed, one of the most important ways to foster leadership is for the MHSS to jointly encourage and support collaborative preventive initiatives.[55] The present picture of the goal and process of using PPIP in the MHSS is characterized by fragmentation rather than collaboration. The rapid proliferation of health promotion innovations among the three services has resulted in considerable variability among the various components contributing to implementing PPIP. This variability, and the lack of a forum to assess its value, make it difficult for the MHSS to select the best sources for health promotion services and materials. Since the ASD(HA) is in a unique position to influence the behavior of the three services within the MHSS, attaining centralized goals for health promotion requires their enthusiastic agreement and active collaborative participation. How can ASD(HA) maintain a philosophy of centralized guidance and decentralized execution, which encourages service ownership and creativity, while, at the same time, providing basic structure and guidelines to promote uniformity?

A common discussion point by attendees at the 1994 Put Prevention Into Practice Implementation Conference, was the need for DOD to provide uniform guidelines to preclude inconsistencies in preventive practices and overcome barriers throughout the MHSS. This includes a mechanism that updates guidelines in close to real time fashion and disseminates them so they are readily available.[56] A major recommendation from the DOD Clinical Preventive Services, Quality Management Review (DOD Report Card), released in February 1996, suggests expanding the education of patients, providers, and staff using DOD-tailored PPIP materials.[57] An ASD(HA) working forum or basic structure, that provide the direction and perhaps even support, is necessary to develop DOD-tailored, MHSS standardized, PPIP practices.

DOD Health Promotion Work Group

The now dormant DOD Health Promotion Coordinating Committee or the currently unchartered DOD Joint Preventive Medicine Policy Group is a potential forum to identify the various PPIP needs, capabilities, effectiveness of existing health promotion efforts, and concerns throughout the MHSS. This

information can then be used in a strategic planning process to develop action plans designed to achieve specific goals related to PPIP dissemination and implementation. Such an organization can serve as a network for rapid, collaborative information exchange. Furthermore, it can serve as the catalyst for the development of an ASD(HA) shared vision that includes the seamless, interactive delivery of preventive services throughout the MHSS. A joint health promotion and disease prevention staff or a chartered working group at the ASD(HA) level can develop PPIP materials and put aside issues of organizational territoriality and forge new areas of cooperation. It can monitor a wide range of health promotional and preventive care issues, and their implications for the MHSS.

Standardization Of Preventive Practices

The ASD(HA) must recognize and address the inconsistencies in preventive practices and existing barriers throughout the MHSS. Collaboration can be a way to develop care-improving partnerships among the three services to help diffusion of PPIP innovations. Several processes within clinical preventive practice, if standardized across the MHSS, hold great promise, while maintaining the diversity and flexibility of PPIP.

A first initiative may be as simple as standardizing forms within the MHSS. The most basic tool for tracking and prompting preventive services is a flow sheet in the patient medical record. The flow sheet is a convenient format for display of the preventive care protocol and has been demonstrated in several studies to improve the delivery of preventive care.[58] The Air Force has designed a preventive care flow sheet that combines the current Master Problem List with an immunization/preventive care flow sheet. The Air Force form is a tremendous product but has had very little, if any, collaboration, at the CHPPM and NEHC level, from the other two services. A joint forum at the ASD(HA) level would offer the opportunity for this type of initiative to be presented, tested and developed into a DOD single form.

Several years ago the Army developed the "Fit To Win" Health Risk Appraisal (HRA). As an automated system used by all three services, the HRA provides demographic, physiological, health assessment and baseline data. It provides an assessment of a Command's health, as well as, information for the development of health promotion programs.[59] In 1995, the Air Force developed the Health Enrollment Assessment Review (HEAR) Survey. This survey represents the current best practice in health assessment.

Initiated in TRICARE Region 6, an integrated product team used a scientific development process to develop the survey, algorithms, and associated computer software.[60] Although this outstanding health assessment survey tool has had minimal collaboration from the CHPPM and NEHC level of the Army and Navy, the ASD(HA) has established the HEAR as the DOD-wide health assessment survey instrument for TRICARE enrollment. The HRA may continue to have some value, but the HEAR Survey is the new instrument of choice.

One might argue that because the TRICARE Regions are triservice, and Region 6 was involved in the survey development, therefore there was a collaborative effort in the HEAR Survey design. The collaboration was predominantly limited to Region 6. The CHPPM and NEHC had very little involvement. This is not a criticism of the Air Force, for their proactive health promotion philosophy can only be commended. However, it points to the nebulous line of authority that exists between the ASD(HA), the Surgeons General offices, CHPPM/OPHSA/NEHC, and the TRICARE Regional Lead Agents for issues pertaining to Preventive Medicine and Health Promotion. This identifies another area requiring further ASD(HA) definition.

In the MHSS, a better translation, management, packaging, and targeted dissemination of PPIP health information and training is needed. Standardized high quality training programs that emphasize the importance of health promotion intervention must be provided to all levels of health care staff within the MHSS. The training must be reinforcing and rewarding. Additionally, the curricula of the military indoctrinal courses (e.g., medical schools, medical residencies, PA and Nurse Practitioner programs, medical technician schools, medical leadership training, continuing medical education programs), must incorporate this training.[61]

As the MHSS competes for patients with civilian health care organizations, PPIP can be used as a marketing tool for TRICARE. This emphasizes the need to ensure that TRICARE clinical preventive service contract language is consistent across TRICARE Regions.

There are several other PPIP related processes that the entire MHSS will benefit from as a DOD-wide effort. The ASD(HA) needs to direct that all MTFs within the MHSS appoint a PPIP coordinator and establish a prevention committee. The Air Force has already taken this prescriptive measure. To ensure

compliance with this directive, PPIP should become an area of special interest in service Inspector General or Command Inspection Programs.

The Air Force is currently alpha testing an automated data system compatible with the existing Composite Health Care System (CHCS) provider workstation platform that tracks clinical preventive services and provides reminders for appropriate preventive interventions. This needs to be a collaborative effort at the Surgeons General level, e.g., CHPPM, OPHSA, NEHC.

Health screening has changed significantly from that of the traditional annual physical examination to a system of age-specific preventive medicine assessments and implementations. The Air Force has already started this type of health assessment with their flight physicals. With a collaborative effort, this can be extended throughout the MHSS.

The self care books issued to beneficiaries as they enroll in TRICARE differs between MTFs and Regions. The standardization of this book, DOD-wide, will not only save money to preclude the issue of another book during a change of assignment, but offer self care continuity throughout a service member's career. In fact, the centralized procurement of all PPIP materials can significantly reduce cost and procurement complexity.

PPIP initiatives must be allied with continuous quality improvement efforts that provide feedback. The current DOD reporting requirements facilitate this effort. The Clinical Preventive Service Management Review (QMR), DOD Report Card, represents the first comprehensive DOD effort to review ambulatory care performance across different clinical interventions and populations.[62] The QMR mirrors the appropriate delivery of clinical preventive services addressed by Healthplan Employer Data and Information Set (HEDIS) and, in the near future, by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Although there is much that ASD(HA) can do to enhance the implementation of PPIP within the MHSS, it does not stand alone. By far, the Air Force Surgeon General has done the most to invest in both the level of professional staff and financial resourcing of Air Force preventive medicine and health promotion. This is reflected in their number of ongoing health promotion innovations, some of which have been mentioned. The Army and Navy need to equally commit to this investment. This can not be just a

token dollar amount, but must include identifying the high motivated PPIP champions, regardless of corps, that will work at the Major Command level. The recent health promotion and prevention grant program by ASD(HA) was a great initiative to allow health care facilities to acquire central funding for progressive prevention programs. This is the type of incentive that will promote innovative thinking for system-wide clinical preventive programs.

CONCLUSION

To play its role fully in the current health promotion environment, the ASD(HA) will have to examine its strategies toward the implementation of preventive health care and health promotion within the MHSS. It will have to decide the value of a collaborative effort with more prescriptive guidance. The three services will have to develop less proprietary attitudes toward their health promotion initiatives and consider approaches combining their special expertise and best practices toward a DOD-wide effort. The PPIP campaign is intended to accomplish more than simply to disseminate a kit of paper-based office and practice tools. It is intended to be a step toward something more important: an approach to preventive care in which not only the three services within the MHSS work together, but the MHSS works with the civilian health care system. The DOD health promotion efforts must be consistent with the comprehensiveness of primary care, and high standards of skill become a routine part of preventive care practice. Additionally, the maintenance of a quality effort in ongoing prevention activities is no less important than desired new programs, and should not be neglected in competing demands on resources or leadership attention. Through collaboration and continued emphasis on disease prevention and health promotion activities, the ASD(HA) and the three services can increase prevention strategies and jointly work toward a healthier and more productive MHSS.

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